General Coding Guidelines

All Medicare carriers process claims using the American Medical Association (AMA) coding structure referred to as Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services' Common Procedure Coding System (HCPCS). These coding publications are updated annually in January.

- A CPT code is a five digit numeric code that accurately describes the physician's service. For example, a routine electrocardiogram, with at least 12 leads and with interpretation and report, would be coded as CPT code 93000.
- A HCPCS code is a five-digit alpha/numeric code that accurately describes physician/non-physician services. For example, a B-12 injection would be coded as HCPCS code J3420 (for the cost of the drug.)

Prior to each new year, Nationwide publishes a *Coding and Reimbursement Guide* for the upcoming year. The guide shows added and deleted CPT and HCPCS codes and/or modifiers.

Each procedure or service you provide to your patient must be submitted to Medicare by using either a CPT or HCPCS code. The CPT or HCPCS code is reported in block 24d of the HCFA1500 claim form or the appropriate electronic format field.

The next most important element of coding is to accurately report your patient's diagnosis, symptom or complaint coded to the highest level of specificity. A diagnosis is submitted to the carrier by using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9 CM). ICD-9-CM codes are updated on an annual basis.

ICD-9-CM Coding for Diagnostic Test

The following instructions provide guidance and are to simplify the appropriate assignment of ICD-9-CM diagnoses codes. These instructions are consistent with the ICD-9-CM Guidelines for Outpatient Services (hospital-based and physician office). Please note that physicians are responsible for the accuracy of the information submitted.

Determining the Appropriate Primary ICD-9-CM Diagnosis Code for Diagnostic Tests Ordered Due to Signs and /or Symptoms.

If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test must code the diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.

Example 1: A surgical specimen is sent to a pathologist with a diagnosis of "mole." The pathologist personally reviews the slides made from the specimen and makes a diagnosis of "malignant melanoma." The pathologist should report a diagnosis of "malignant melanoma" as the primary diagnosis.

Example 2: A patient is referred to a radiologist for an abdominal CT scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess. The radiologist should report a diagnosis of "intra-abdominal abscess."

Example 3: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "cough." The chest x-ray reveals a 3cm peripheral pulmonary nodule. The radiologist should report a diagnosis of "pulmonary nodule" and may sequence "cough" as an additional diagnosis.

If the diagnostic test did not provide a diagnosis or was normal, the interpreting physician must code the sign(s) or symptom(s) that prompted the treating physician to order the study.

Example 1: A patient is referred to a radiologist for a spine x-ray due to complaints of "back pain." The radiologist performs the x-ray, and the results are normal. The radiologist should report a diagnosis of "back pain" since this was the reason for performing the spine x-ray.
Example 2: A patient is seen in the ER for chest pain. An EKG is normal, and the final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). The patient was told to follow-up with his primary care physician for further evaluation of the suspected GERD. The primary diagnosis code for EKG should be chest pain. Although the EKG was normal, a definitive cause for the chest pain was not determined.

If the results of the diagnostic test are normal or non-diagnostic, and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probable, suspected, questionable, rule out, or working), then the interpreting physician must not code the referring diagnosis. Rather, the interpreting physician must report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as uncertain are considered by the ICD-9-CM Coding Guidelines as unconfirmed and must not be reported. This is consistent with the requirement to code the diagnosis to the highest degree of certainty.

Example: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "rule out pneumonia." The radiologist performs a chest x-ray, and the results are normal. The radiologist should report the sign(s) or symptom(s) that prompted the test (e.g., cough).

Instruction to Determine the Reason for the Test
As specified in the Balanced Budget Act (BBA), referring physicians are required to provide diagnostic information to the testing entity at the time the test is ordered. All diagnostic tests "must be ordered by the physician who is treating the beneficiary." As defined in §15021 of the *Medicare Carriers Manual* (MCM), an "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:
A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;
A telephone call by the treating physician/practitioner or his/her office to the testing facility; and
An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

Note: If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

Example: A patient is referred to a radiologist for a gastrograffin enema to rule out appendicitis. However, the referring physician does not provide the reason for the referral and is unavailable at the time of the study. The patient is queried and indicates that he/she saw the physician for abdominal pain, and was referred to rule out appendicitis. The radiologist performs the x-ray, and the results are normal. The radiologist should report the abdominal pain as the primary diagnosis.

Incidental Findings
Incidental finding must never be listed as primary diagnoses. If reported, incidental findings may be reported as secondary diagnoses by the physician interpreting the diagnostic test.

Example 1: A patient is referred to a radiologist for an abdominal ultrasound due to jaundice. After review of the ultrasound, the interpreting physician discovers that the patient has an aortic aneurysm. The interpreting physician reports jaundice as the primary diagnosis and may report the aortic aneurysm as a secondary diagnosis because it is an incidental finding.
Example 2: A patient is referred to a radiologist for a chest x-ray because of wheezing. The x-ray is normal except for scoliosis and degenerative joint disease of the thoracic spine. The interpreting physician reports wheezing as the primary diagnosis since it was the reason for the patient's visit, and may report the other findings (scoliosis and degenerative joint disease of the thoracic spine) as additional diagnoses.
Example 3: A patient is referred to a radiologist for a magnetic resonance imaging (MRI) of the lumbar spine with a diagnosis of L-4 radiculopathy. The MRI reveals degenerative joint disease at L1 and L2. The radiologist reports radiculopathy as the primary diagnosis and may report degenerative joint disease of the spine as an addition diagnosis.

Unrelated/Co-existing Conditions/Diagnoses
Unrelated and co-existing conditions/diagnoses may be reported as additional diagnoses by the physician interpreting the diagnostic test.

Example: A patient is referred to a radiologist for a chest x-ray because of a cough. The result of the chest x-ray indicates the patient has pneumonia. During the performance of the diagnostic test, it was determined that the patient has hypertension and diabetes mellitus. The interpreting physician reports a primary diagnosis of pneumonia. The interpreting physician may report the hypertension and diabetes mellitus as secondary diagnoses.

Diagnostic Tests Ordered in the Absence of Signs and/or Symptoms (e.g. screening tests)
When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the physician interpreting the diagnostic test must report the reason for the test (e.g. screening) as the primary ICD-9-CM diagnosis code. The results of the test, if reported, may be recorded as additional diagnoses.

Use of ICD-9-CM to the Greatest Degree of Accuracy and Completeness

This section explains certain coding guidelines that address diagnosis coding. These guidelines are longstanding coding guidelines that have been part of the *Official ICD-9-CM/Guidelines for Coding and Reporting.*

The interpreting physician must code the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from test, or for the sign(s)/symptom(s) that prompted the ordering of the test.

In the past, there has been some confusion about the meaning of "highest degree of specificity," and in "reporting the correct number of digits." In the context of ICD-9-CM coding, the "highest degree of specificity refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis.

Example 1: A chest x-ray reveals a primary lung cancer in the left lobe. The interpreting physician should report the ICD-9-CM code as 162.5 for malignancy of the left "lower lobe, bronchus or lung," not the code for a malignancy of "other parts of bronchus or lung" (162.8) or the code for "bronchus and lung unspecified" (162.9).
Example 2: If a sputum specimen is sent to a pathologist and the pathologist confirms growth of "streptococcus, type B" which is indicated in the patient's medical record, the pathologist should report a primary diagnosis as

482.32 (Pneumonia due to streptococcus, Group B). However, if the pathologist is unable to specify the organism, then the pathologist should report the primary diagnosis as 486 (Pneumonia, organism unspecified).

In order to report the correct number of digits when using ICD-9-CM, refer to the following instructions:

ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with 3 digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and /or fifth digits to provide greater specificity. Assign three digit codes only if there are no four digit codes within that code category. Assign four-digit codes only if there is no fifth-digit subclassification for that category. Assign the fifth-digit subclassification code for those categories where it exists.

Example 3: A patient is referred to a physician with a diagnosis of diabetes mellitus. However, there is no indication that the patient has diabetic complications or that the diabetes is out of control. It would be incorrect to assign code 250 since all codes in this series have 5 digits. Reporting only three digits of a code that has 5 digits would be incorrect. Two digits must be added to make it complete. Because the type (adult onset/juvenile) of diabetes is not specified, and there is no indication that the patient has a complication or that the diabetes is out of control, the correct ICD-9-CM code would be 250.00. The fourth and fifth digits of the code would vary depending on the specific condition of the patient. Providers should be guided by the code book.

For the latest ICD-9-CM coding guidelines, please refer to the following website: http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guide.

Diagnoses must be referenced on the patient's Medicare claim utilizing a single digit numeric reference code (1, 2, 3, or 4), for each service submitted by the provider. Each one-digit numeric reference code is reported in block 24e of the HCFA-1500 claim form or the designated electronic formatted field. These indicators reference the diagnosis codes reported in block 21 of the HCFA-1500 claim form or the designated electronic formatted field. Multiple diagnoses can be submitted on a single claim that allows the physician to match the specific diagnosis code reported to the corresponding service that was provided to the Medicare patient.

ICD-9-CM diagnosis codes that are not coded to the highest possible level of specificity will cause a claim to be rejected. The claim must be corrected and resubmitted as a new claim. A patient may not be billed for any service if the physician fails to code the diagnosis to the highest level of specificity.

Reference Materials

There are several reference materials that have been mentioned throughout this book that will help when coding and filing claims to the Medicare carrier. All Medicare carriers update their Current Procedural Terminology (CPT) and Health Care Financing Administration Common Procedure Coding System (HCPCS) codes annually. Procedure code changes are updated annually. The effective date is January 1 with a 90-day grace period through March 30. Diagnosis codes are updated annually, effective October 1.

Reference Materials For Your Office:

- **Level I CPT Code Book**
- **ICD-9-CM Coding Book**
- **Annual Coding and Reimbursement Guide**
- ***Medicare Newsletters***

Medicare Part B Publications

Visit our website www.nationwide-medicare.com for our most current publications including the Medical Policy Manual, *Medicare Newsletter*, and fee schedule information. Information may also be requested by writing to:

Medicare – Disclosure
PO Box 182947
Columbus OH 43218-2947

Medicare Relative Value Units

Medicare Relative Value Unites (RVUs) are assigned to each procedure code and published yearly in the Federal Register. The Federal Register provides the procedure code, status indictor, relative value units, global period, and update factor information. We do not provide copies of this government publication. Many public and academic libraries have the Federal Register available for viewing and photocopying. You may request copies from:

Superintendent of Documents
U.S. Government Printing Office
PO BOX 371954
Pittsburgh PA 15250-7954

Order desk phone: 1-888-293-6498 (toll free). The Federal Register is also available on the Internet at www.access.gpo.gov/sudocs.

UPIN Directories

A directory of UPIN numbers can be found on the following Internet address: www.automateddc.com/queries/upin.asp. You may also obtain a CD-ROM directory from Nationwide; please refer to the UPIN section in Chapter 3 or refer to our website at: www.nationwide-medicare.com.

Free Medicare Education

CMS is now offering free Medicare education for all Medicare providers and their staff. This training is available on the following Internet site: www.medicaretraining.com.

Nationwide also offers the services of District Managers dedicated to provider education and training. The District Managers are available for seminars. Please refer to the Contacts in Chapter 1, or to the back of your most recent *Medicare Newsletter* for the telephone number of the District Manager responsible for your geographic area.

Special Claims Filing Reference Items

The following sections in this chapter provide information on various topics important in proper filing of Medicare claims. These items address billing rather than medical policies. For ease of reference these items are provided in alphabetical order.